

Chapter Ten

Chapter Ten



Child and Family Well-Being

- 1. Frequency of contact between caseworkers and children and their families. Examine any data the State has available about the frequency of contacts between caseworkers and the children and families in their caseloads. Identify and discuss issues that affect the frequency of contacts and how the frequency of contacts affects the outcomes for children and families served by the State.**

I. Overview

CA has three major policies that govern timeliness and frequency of contact between caseworkers and children. The policies include: (1) timely response to referrals regarding abuse and/or neglect, (2) 90-day visitations with children in care and (3) a visitation policy outlining contact with children monitored by an in-home dependency. These policies are outlined in the Practices and Procedures Manual.

II. Program Description and Policy Information

(1) Timeliness of Response to Referral Regarding Abuse and/or Neglect

Policy

Upon receipt of a non-emergent referral for child abuse and/or neglect, policy provides a worker with 10 calendar days to begin an investigation, and 10 working days to conduct a face-to-face interview with the child. If a referral is tagged as an emergent response, the worker has 24 hours to initiate the investigation.

Data Measure

Timeliness of investigations (i.e. 10-day face-to-face contact) is currently tracked by quarterly regional hand counts. Reports using the CAMIS Service Episode Record (SER) documentation have recently been developed. The performance target for this measure is currently 90 percent (recognizing that there will always be some policy waivers, which give legitimate reasons why all children cannot be seen within the timeframe).

In the past, regional hand counts have been used to report progress in seeing children within the required timeframe. However, CA will be moving towards the use of CAMIS SER documentation for this purpose.

Statewide data shows performance on this measure to be at 87% based on the hand counted data, and 56% based on documentation in SER. In addition, of the offices that have participated in peer case record reviews, the findings show that 78% of initial face-to-face contacts are completed within the timeframe. While it is likely that the actual practice of seeing children within the timeframe is fairly close to the target (90%), the documentation of the face-to-face contact in CAMIS is not.

CA is moving to using SER documentation for measuring timeliness of investigations. All offices will be expected to meet the performance measure target of 90% in conducting the 10-day face-to-face contact, by SER count. To support the measure, all contacts must be documented in CAMIS SER. The CFSR, the accreditation onsite review as well as the central and peer case record reviews base their findings on documentation being entered into CAMIS.

(2) 90-Day Health and Safety Visits for Children in Out-of-Home Care

Policy

CA's goal is to maintain social worker visitations with children in out-of-home care at least every 90-days. The visitations are designed for the social worker to assess the health and safety of the child in the placement, and to determine if the child's needs are being met.

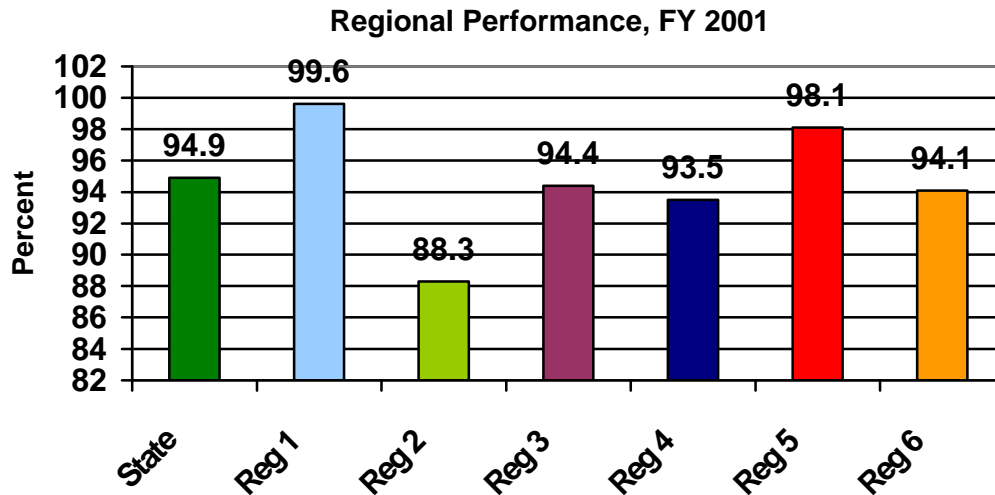
During the 90-day health and safety visit, social workers are expected to ask the child's caregiver about the health, safety, and emotional well-being of the child. Inquiries may include information about the child's daily routine, school progress, adjustment, behavior, discipline, significant events in the caretaker's residence that might impact the care of the child, and special needs of the child.

With non-verbal children or infants, social worker observation must be particularly acute. The social worker must document in the SER how the child appears developmentally, physically and medically. In addition, the social worker assesses and documents how the caretaker responds to the child, whether the caretaker has appropriate support systems, and whether others besides the primary caretaker are appropriate with the child.

Data Measure

Due to the inconsistency of documentation of the 90 day visits in the information system, CA previously initiated hand counting of the visits, in an attempt to gain more accurate information. For the Fiscal Year (FY) 2001, Chart 1 reflects the regional percentage of compliance with this policy, as per hand count.

Chart 1. Regional Performance on 90-day Health and Safety Visitations



(Measured by Hand Count)

(Source: Children's Administration Data Management Unit, Monthly Trend Report, October 2002)

As reflected in Chart 1, in FY 2001, hand counts of data show that Regions 1 and 5 were exceeding the performance measure of 95% for 90-day health and safety visits. Region 2 fell below the rest of the state, with 88.3%. Overall, statewide performance on the 90-day health and safety for FY 2001 was at 94.9%.

In FY 2002, measures from SERs were calculated to determine compliance with this performance measure. According to the SER calculation, only 34.3% of 90-day health and safety visits with children in out-of-home care were documented in CAMIS. This reflects the inconsistency between what is reported and what is entered into the information system.

In addition, of the offices that have participated in peer case record reviews, the findings show that, in 2001, 57% of 90 day health and safety visits were completed in Child Protective Services (CPS) (n=47), and 66% of visits were completed in Child Welfare Services (CWS) (n=447).

There continues to be a discrepancy in data collection regarding the number of visits being hand counted versus those that are calculated using measures from SERs, and those that are found during the peer review process. One possible explanation for the discrepancy may be that social workers are not always documenting the visits into CAMIS, or that they are not using the correct SER code for documentation. Runaways and other unforeseen circumstances can also interfere with the ability of social workers to conduct the required visits. In addition, case

worker turnover, caseload size and composition, and timely case record transfer can also affect achievement of the 95% goal for quarterly visits.

CA management has decided to develop a policy that will require visits with children every 30 days, with one of these visits being in the child's home every 90 days. The policy change will enable CA to comply with the Accreditation standards related to visitation. Workgroups, including union representation, are being established to assist in planning implementation and policy development. It is expected that this policy will be developed and implemented in the fall of 2003.

(3) Visitation with Children Placed on an In-Home Dependency

Policy

CA has established additional monitoring requirements for children remaining with or being returned home to a parent who has abused or neglected a child. The requirements for monitoring timeframes depend upon the age of the child.

Children placed in their own homes, who are subjects of dependency actions, may be at risk for child abuse and neglect, as well as serious adjustment problems within the parent's home. These monitoring requirements establish CA procedures for situations in which children are subjects of dependency filings and either remain in the home, or are subsequently returned home to a parent who has abused a child.

For the first 120 days of placement for children from birth to five years of age, visits must occur at least two times per month. The required visits can be conducted by the DCFS social worker, DCFS paraprofessional, a contracted provider involved in the safety plan, or a non-contracted professional participant in the safety plan.

The purpose of the visits is to conduct a health and safety check. The child must be observed in the family home, and observation must include a review of the physical environment, the child's sleeping arrangements, the parent-child interaction, and monitoring for problems with the child's physical development and injuries. After 120 days, the requirement for health and safety monitoring is once a month.

For the first 120 days of placement for children from six to eighteen years of age, visits must occur once per month. The DCFS social worker, DCFS paraprofessional, contracted provider involved in the safety plan or non-contracted professional participant in the safety plan can conduct the visits. The DCFS social worker will visit at least every 60 days, including one visit in the first 30 days. These contacts need to include a private discussion with the child, if the child is verbal, concerning his or her adjustment and safety in the home. Other than the required 90-day in-home health and safety checks, which need to occur in the placement facility, these other contacts may occur outside the placement facility, in a setting where the child feels comfortable to discuss issues of concern.

After 120 days, for children age six to eighteen, the DCFS social worker must visit in the family home every 90 days, and do a health and safety check. Part of the visit includes an interview with the child outside the presence of the caregiver. Additional visits may occur in intervening months by the DCFS social worker, DCFS paraprofessional, contracted provider involved in the safety plan or non-contracted professional participant in the safety plan in the home or outside the home.

Data Measure

The minimum requirements for the frequency of visits outlined above were effective May 1, 2001, and revised November 1, 2002. A CAMIS process has not yet been developed for data collection on compliance with the required visitation policy for children on in-home dependencies. However, beginning in the fourth quarter of 2002, the case review tool was revised to include compliance with this measurement.

Caseworker Visitation with Families and Caregivers

Policy

CA does not have a policy to guide workers in the frequency of contact with families and caregivers of children. Although many workers have frequent contact, there needs to be a consistent requirement of contact, in order to involve the families and caregivers in case planning. In addition to increasing the timelines for caseworker visits with children, CA management has decided to develop a policy to require social workers to have contact with families and caregivers every 30 days. The policy change will enable CA to comply with Accreditation standards, and will allow for families and caregivers to be more involved in case planning. Workgroups, including union representation, will be established to assist in the planning and development of this policy. It is expected that this change in policy will occur in the late 2003.

Data Measure

Since there has not been a policy regarding the frequency of caseworker visitation with families and/or caregivers, no data is available to determine how often this is occurring.

III. Initiatives

Case Review Model

Once the above visitation policy changes are made and implemented, the case review model will be revised to include the new measures. Case reviews will then assess compliance with these areas.

IV. Lessons Learned During the Statewide Assessment

Strengths

- Hand counts of compliance with 90-day Health and Safety visits show that the state is at 94.9% compliance.
- CA has decided to develop a policy that will require visits with children, parents and care-givers every 30 days. Workgroups with union representation have been established to assist in framing of the policy and implementation is scheduled for late 2003.
- The policy for visits with children who are placed on an in-home dependency has been developed and has been implemented statewide.

Challenges

- There are discrepancies between hand counted data and data calculated using the CAMIS SER code for the required 10-day face-to-face contacts with victims in the process of the investigation, and for 90-day health and safety visits. As CA moves to CAMIS counts of all data there will be a need to monitor and ensure that all visitations are appropriately coded and documented in the CAMIS data base.
- There is currently no process (via CAMIS) in place to track the level of compliance with the visitations for in-home dependencies.

Promising Practice

CA's Strategic Plan (2003-2009) addresses several areas regarding contact and visitation issues. Strategies for these areas include clarifying policy issues surrounding the initiation of timeliness of investigations; increasing worker visits with the child by moving to 95% of social workers visiting in the caregivers' home at least every 90 days, and the development of a policy to increase contact with children in care. In addition, the Strategic Plan addresses the plan to increase social worker visits with parents, children, and caregivers to once every 30 days. (Refer to CA Strategic Plan, 2003-2009, Strategic Outcome S-1, and WB-1).

2. **Educational Status of Children.** Examine any data the State has available regarding the educational status of children in its care and placement responsibility. How does the State ensure that the educational needs of children are identified in assessments and case planning and that those needs are addressed through services?

I. Overview

CA has policies and programs in place to ensure that the educational needs of children in care are identified, and that those needs are addressed in case planning.

The Washington State Institute for Public Policy completed a report titled “Educational Attainment of Foster Youth: Achievement and Graduation Outcomes for Children in State Care” (November 2001), which analyzed the educational attainment of youth in foster care in Washington and the public school system.

The report revealed that in statewide achievement testing, children in foster care score, on average, 15 to 20 percentile points below children not in foster care. In addition, only 59% of youth in foster care enrolled in 11th grade completed high school by the end of grade 12. The completion rate for children not in foster care is 86%.

Even after statistically controlling for a variety of factors, a child who enters foster care is likely to have lower test scores and graduation rates than a child who is not in foster care. In addition, in both elementary and secondary school, twice as many children in foster care had repeated a grade, changed schools during the year, or enrolled in special education programs.

According to the study by the Washington State Institute for Public Policy, a youth’s length of stay in foster care and other placement characteristics do not appear to be related to educational attainment. Children placed in short-term foster care, for example, have on average the same educational deficits as children placed in long-term foster care.

II. Program and Policy Information

Assessment of Educational Needs

Kidscreen

Kidscreen is a legislatively mandated screening program designed to assess the needs of children who are placed in out-of-home care. Implementation of the Kidscreen program began statewide on September 15, 2001, in an effort to provide "front end" planning for children who remain in care longer than 30 days. Washington state requires that a Kidscreen be conducted for children within their first 30 days of placement. Kidscreen assesses condition and level of functioning in five life domains: physical/medical, developmental, educational, family/social and emotional/behavioral. Results of the screenings are utilized in creating the individualized service plans for each child. As part of assessing the educational level of children in care, Kid-

screen Specialists work with local schools to obtain copies of Individual Education Plans for children in care.

Foster Care Passport Program

The Foster Care Passport is primarily focused on the collection of health related data, including immunizations. However, occasionally, educational information is received in addition to health information. It is not a requirement of the Passport program to collect education information, but, the Passport nurses enter what educational data they have into the CAMIS system, typically demographic data. The primary responsibility for entering educational information into CAMIS lies with the social worker.

Planning for the Child's Educational Needs

The child's educational needs are described by the social worker in the Individual Service and Safety Plan (ISSP). For youth 16 and over, the ISSP must also address independent living skills, including educational goals, income maintenance (including health care coverage), vocational goal attainment, knowledge of how to secure adequate housing, daily living skills and interpersonal skills (including connections to extended family or other significant adults).

Data Trends

High School/General Equivalency Diploma or Educational/Vocational Enrollment

A small proportion of the older children who are placed in temporary foster care will not be placed in a permanent home prior to their eighteenth birthday. Historically, children who "age out" of the child welfare system while still in foster care are less likely to be educationally and vocationally equipped for independent adulthood. In an effort to obtain data about the levels of educational attainment for this group, CA conducts an annual hand count of the educational status of youth age 18 or older who have been in care for at least one year and who left care without being placed into a permanent home, or are in guardianships and receiving services from CA. The hand count identified 274 youth meeting this criteria during CY 2001. Social workers were asked to indicate whether the youth had received a high school diploma or General Equivalency Diploma (GED) prior to the time they left care. If the youth had not obtained such a diploma, the social worker was asked whether the youth was attending or enrolled in an educational or vocational program at the time they left care.

Of the 274 youth identified, 70% had either obtained a diploma, GED, or were enrolled in an educational or vocational program at the time of leaving care. Thirty-four percent of the youth had received a high school diploma, 13% had obtained a GED, and 23% were enrolled in an educational or vocational program. Forty-seven percent of children aging out of foster care graduated from high school or obtained a GED. Of the 47% completing high school or equiva

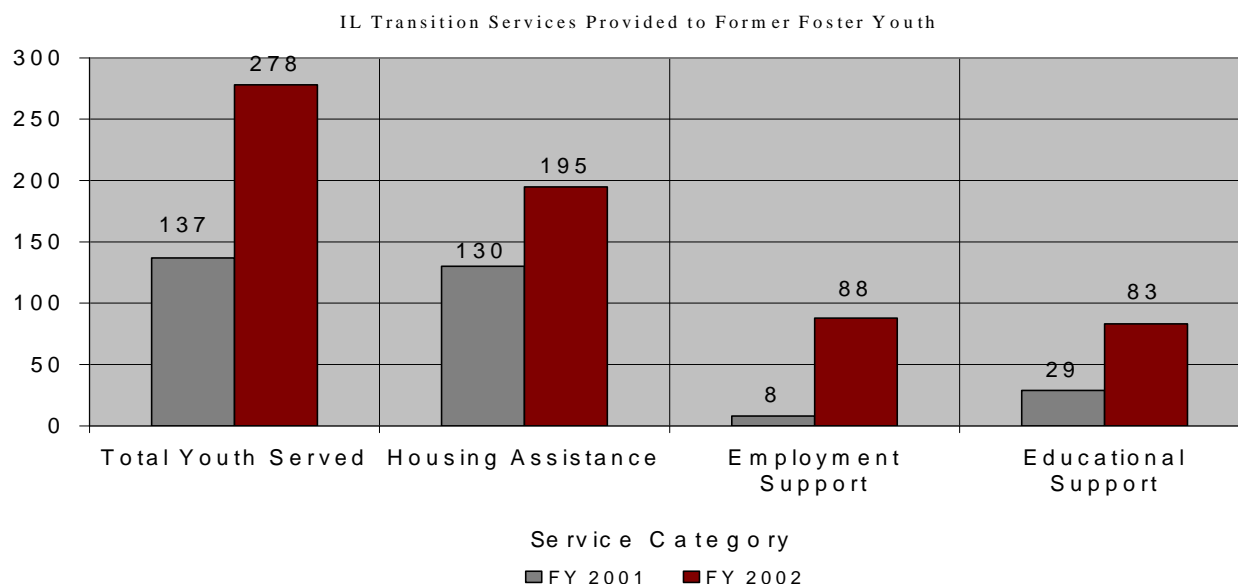
lency in Washington State, 19% planned to pursue higher education. CA is currently developing outcome measures and a data tracking system to improve the accuracy of educational outcome data collection and reporting.

Youth in Care who Receive Independent Living Services

In 1999, the federal Chafee Foster Care Independence Act replaced the existing Independent Living Program, clarifying the mission and expanded funding to States for the provision of Independent Living Services (ILS). The Chafee Act calls for states to identify those youth who are most likely to remain in foster care until the age of 18, and who are least likely to have family support systems upon exiting from foster care.

The new legislation allows states to provide services to youth at an earlier age (13+) and allows states to continue to provide support and transitional services to youth through age 20. The ILS program has contracted providers in every DCFS Region, plus contracts with 23 different tribal entities. Social workers may refer a youth age 16-18 to an ILS provider for a comprehensive skills assessment, plan development, and training. Social workers may then use these documents to complete the required independent living section of the Youth's ISSP. For youth age 16-18 not enrolled in an ILS program, the social worker has sole responsibility for developing and writing the independent living plan. The total number of foster children (18-21) who received independent living transition services and the type of services received are presented in Table 1.

Table 1. Independent Living Transition Services Provided to Former Foster Children (Ages 18-21)



(Source: Children's Administration Performance Report, 2002)

Note: In Table 1, the youth served may have received services in more than one category, thus the sum total of youth served in each category will exceed the sum of all youth served in the "Total" columns.

Individual Education Plans (IEP)

For children in placement who have special education needs, schools create an Individual Education Plan (IEP) that addresses the child's specific needs. As part of the Kidscreen process, this information is collected when a child enters out-of-home care. Table 2 reflects the number of children with and without an IEP between July 2001 and June 2002.

Table 2. School Age Children in Placement in Special Education

July 2001 – June 2002

Children without an IEP	AGE (years)	TOTAL
	5-10	1592
	11-13	699
	14-18	867
	Total	3158
Children with an IEP	AGE (years)	TOTAL
	5-10	266
	11-13	133
	14-18	117
	Total	516
Total Sum of 5-10 years		1858
Total Sum of 11-13 years		832
Total Sum of 14-18 years		984
Total Sum		3674

(Source: The table was extracted from the report to the legislature, Coordinated Services and Educational Planning for Children in Out-of-Home Care, November 1, 2002).

III. Initiatives

Coordinated Services and Educational Planning for Children in Out-of-Home Care

On November 1, 2002 the Department of Social & Health Services (DSHS) published a report to the legislature titled, *Coordinated Services and Educational Planning for Children in Out-of-Home Care*. This report was in response to a legislative mandate (Senate Bill 6709) that instructed CA, in cooperation with the Office of the Superintendent of Public Instruction (OSPI), to establish a plan to ensure the best interests of the child were a primary consideration in the school placement of a child in short-term foster care.

In response to the mandate, CA and OSPI established a workgroup to prepare a plan to address educational stability and continuity for school-age foster children who enter into short-term foster care. Specifically, the plan was required to address: 1) ensuring the best interest of the child are a primary consideration in the school placement of a child in short-term foster care; 2) determining the current status of school placement for children placed in short-term foster care; and 3) identifying options, within existing resources, available to keep children placed in short-term foster care in the school where they were enrolled prior to placement.

In addition to addressing the specific legislative mandate, the workgroup also identified practice changes that would increase collaboration and communication between and OSPI and CA, and maximize the likelihood of foster children being able to remain in their home schools.

Team Child

Team Child is a non-profit legal services organization with offices based in King, Pierce, Spokane and Yakima Counties. With the support of Casey Family Programs, Team Child has published an educational advocacy manual, targeted to children and youth who are out of home or in foster care titled, "Make a Difference in a Child's Life: A Manual for Helping Children and Youth Get What They Need in School." The manual includes information on educational advocacy, student rights, and special education laws. In addition, the manual provides copies of forms and other materials needed to request educational records. Regions 2, 4, and 6 have purchased the manuals. Additional manuals were distributed to DCFS offices and private agency contractors serving adolescents in July, 2003.

Casey Family Programs Training

Casey Family Programs has a series of three in-service classes for school personnel targeted at improving educational outcomes for youth in out-of-home care. Topics include training on what foster care is, understanding what foster children are experiencing, and educational support for youth in out-of-home care.

Court Appointed Special Advocate (CASA) Grant

CASA has a 3-year Stuart Foundation grant on permanence and educational advocacy. The purpose of the grant is to study how the CASA volunteer can be involved in educational advocacy and what constitutes best practice, i.e., how to access all the various systems, how to make sure the child gets evaluated for special education, etc. Although CASA's may experience turnover, it is expected that this approach would be effective because it is intended that the CASA volunteer remains with the child through every change in social worker, foster home and school.

Treehouse

Casey Family Programs, Region 4 DCFS, and Treehouse have entered into a partnership to provide educational supports for children. Treehouse in King County provides tutoring, school supplies (via ILS funds, ages 13-17) and has placed an educational advocate in the DCFS King South (Kent) office. The educational advocate works with children who are struggling in school, and provides assistance with IEP's.

In addition, Treehouse has a program titled Coaching to College. This program is focused on providing tutoring and coaching toward completion of high school diploma or GED. In addition, the program provides assistance with college applications and financial aid.

Governor's Scholarship Fund

The Governor's Scholarship Program for Washington Youth in State-Recognized Foster, Group and Kinship Care provides scholarships to youth in out-of-home care in Washington and helps them to enroll in and complete college. The Washington Education Foundation (WEF) manages the program.

The Governor's scholarships are renewed until graduation, as long as recipients maintain "satisfactory academic progress" at their colleges and continue to have high financial need levels. Awards are limited to four years for students working on four-year college degrees and for the normal duration of the course of study for programs that are less than four years. In 2002, 18 scholarships were awarded to young people in care, and 24 more scholarships were awarded this year.

Foster Care and Education Consortia

Casey Family Programs, Region 4 DCFS, Seattle School District, and Team Child have partnered to pilot a program to increase information sharing between agencies in Region 4. The pilot is in the early stages, and there is no feedback on the project available at this time.

Education Improvement Projects

There are numerous projects in each region directed at improving educational services. The fol-

lowing is a list of regional educational improvement projects, funded partially by federal Independent Living Funds:

Region 1

- Purchased Sylvan Learning Center tutoring slots for youth 13 to 17.
- CASA project to assist young people with college scholarship applications.

Region 2

- Completed the Get Set summer program (2002). This was a collaboration between Catholic Child and Family Services, Casey Family Programs and the Yakima DCFS office. The program is an intensive independent living skills course with volunteer work experience. Foster youth are paid a stipend for participation.
- Developed an Education Center in collaboration with EPIC (a private, non-profit child and family serving agency). The center provides education advocacy, tutoring services using the “strategic tutoring model” and foster parent coaching/training.
- The GET SET program will run again summer 2003.

Region 3

- Completed a summer program for youth 16 to 21 (2002). The program focused on vocational skill building, employment readiness and positive youth development.
- The program will be offered again this summer.
- Applied for a federal grant called the Youthbuild program. This program provides construction training opportunities to youth who have dropped out of school.
- The Mount Vernon transportation project

Region 4

- Purchased additional advocacy and tutoring slots through the Treehouse program.
- Developing education protocols between the Region 4 DCFS offices and the Seattle School district.
- Provide the coaching to college program.

Region 5

- Purchased Sylvan Learning Center tutoring slots for youth ages 13 to 15.
- Pursuing school-based, foster home recruitment to keep children in schools of origin.

Region 6

- Purchased Sylvan Learning Center tutoring slots.
- Developed multidisciplinary teams with most school districts in Lewis county.
- Began a pilot project for school-based foster home recruitment with the Olympia, Tumwater and North Thurston school districts.
- Planning Regional Education Improvement conferences.
- Piloting the Judicial, Education checklist in Aberdeen.

Children's Administration

- Completed a 6 month study of the educational well-being of 40 youth from around the State.
- Provided technical assistance and oversight of current pilot projects.
- Sponsored a statewide conference with community partners on July 31, 2003 (*Launching Futures Together*). One area of focus was a presentation and interactive work group on strategies for educational advocacy and intervention steps for older youth in foster care.

IV. Lessons Learned During the Statewide Assessment

Children in placement with an Individual Education Plan

The Kidscreen evaluations were used to identify the number of children who were receiving special education services. The Kidscreens document whether a child has an IEP. From the Kidscreen data, 516, or 14% of the 3,674 school age children who entered an out-of-home placement, during this time period were receiving special education services.

Of the Kidscreens conducted between September 15, 2001 and December 19, 2002, 51% of files did not receive educational records. Of the 919 cases that did not receive educational records, 55% had been requested by CA, but had not yet been received.

Passport Program

According to data received from the Washington State Institute for Public Policy report titled "*Educational Attainment of Foster Youth: Achievement and Graduation Outcomes for Children in State Care*" (November 2001), out of all active foster care placements in August 2001, 5,552 children had a completed Passport. Only 793 (14%) of the Passports included any information related to the foster child's education. According to the report, high caseloads and difficulty obtaining records from schools prevent the vast majority of social workers from updating Passports with educational information.

Recommendations for Changes in Practice

Practice changes that were recommended in the November 1, 2002 DSHS report titled, "*Coordinated Services and Educational Planning for Children in Out-of-Home Care*" include:

- Developing DCFS/school district protocols or interagency agreements to maximize educational continuity for foster children in districts with high removal and placement rates.
- Emphasizing placements that allow children to remain in their home school whenever feasible. Whether or not children remain in their home school, social workers or their designees should notify the school when a child is removed into foster care.
- The social worker or foster parent should notify the school of the child's foster care status at time of enrollment.

- Each school should identify a liaison to know and work specifically with foster children.
- CA and the Administrator of the Court should work together to make sure educational stability is addressed during court hearings.
- Relevant parties should support statewide utilization of a judicial checklist to be used by Judges and Commissioners with regard to educational stability.
- CA should focus foster care recruitment efforts in school districts with high rates of removal to foster care.

Strengths

- CA has initiated a broad range of programs to help meet the educational needs of children in care.
- Confidentiality issues and automated data sharing between CA and the Office of the Superintendent of Public Instruction (OSPI) are being actively explored. The ultimate goal is to have OSPI data automatically populate the education data fields of the Passport, similar to the way immunization data is currently downloaded from the Department of Health.
- SB 6709 initiated coordinated planning for and addressing the educational needs of children in care. Partnerships have been developed and recommendations have been made as to how agencies can move forward to address this issue.
- Independent Living Services are available to youth in every region and a significant portion of these services focus on educational support.

Challenges

- Children who enter foster care are likely to have lower test scores and graduation rates than a child who is not in foster care, regardless of the length or type of placement.
- 14% of children in care have special education needs and an Individual Education Plan (IEP).
- The majority of Foster Care Passports contain little, if any, educational information.
- In an attempt to avoid a conflict of interest, federal law prohibits social workers from being designated as the “Surrogate Parent” for a student with special education needs. This makes it difficult for CA to advocate for the educational needs of the child and participate in the development of the IEP. (*Refer to Individuals with Disabilities Education Act*)

COA Self-Study

The Council on Accreditation (COA) standards require that the organization obtains, coordinates, and supervises the provision of medical, dental, educational, recreational, or other specialized services and resources described in the service plan. In addition, the organization is required to work with foster parents, kinship caregivers, schools, and other relevant stakeholders to help the child achieve his/her full educational potential. According to the Statewide Self-Study, there is enough evidence to support passing this standard. (*Refer to S-21, COA Standards, for additional information.*)

Promising Practice

CA's Strategic Plan (2003-2009) includes strategies to improve educational outcomes for children in care, in conjunction with collaboration with agency partners. Improvement of educational outcomes includes strategies to improve tracking of educational status, to develop training to support the education of children, and to encourage the school districts to have a liaison from each school who works specifically with children in out-of-home care. In addition, agency strategies include plans to implement SB 6709 to develop protocols and procedures for maintaining children in their school of origin when they are placed in care. (*Refer to Strategic Plan, Strategic Outcome O-1, WB-1, and WB-2.*)

CA is developing a process to create state and regional child profiles from Kidscreen data. These profiles will help identify services, including educational services, needed to meet children's needs.

3. Health care for children.

Examine any data the State has available regarding the provision of health care, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), to children in its care and placement responsibility. How does the State ensure that the physical health and medical needs of children are identified in assessments and case planning activities and that those needs are addressed through services?

1. Overview

CA identifies the physical health and medical needs of children in care through the use of assessments that are incorporated into the case planning process. CA uses the Early and Periodic Screening, Diagnosis and Treatment, Kidscreen, Passport and the Foster Care Assessment Programs. In addition, there are a variety of other programs that support the health care needs of children in care by gathering medical histories and developing plans to meet health care needs.

The information that is gathered for each child is included in the Individual Safety and Service Plan (ISSP). The service plans are developed around the needs of the child, and include plans for addressing any health care issues that the child may have.

II. Program Policy Information

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment examination is also referred to as the well-child examination. CA policy requires that children entering into out-of-home care have a completed well-child examination within 30 days of placement.

During 2001 CA and the Medical Assistance Administration (MAA) collaborated on strategies to increase the number of foster children receiving EPSDT examinations. This included an increased payment for medical providers who conduct well-child examinations for children in foster care, beginning November 2001.

The emphasis on obtaining well-child examinations to complete the Kidscreen, combined with the increase in the provider payment for well-child exams, has contributed to a dramatic increase in the number of children obtaining well-child examinations early in their placement.

Data

Statewide, 72%, or 2,363 children, have completed well-child EPSDT. The majority of these children (1,365) are receiving the examinations within 30 days of placement. For those children not receiving well-child examinations during the first 30 days, 47% (427) have appointments scheduled, and 384 children received well-child examinations between 30 to 45 days of placement.

Kidscreen

Policy

Kidscreen is a legislatively mandated screening program designed to assess children who are placed in out-of-home care. Implementation began statewide on September 15, 2001 in an effort to begin early health assessment and planning for children who will remain in care for longer than 30 days.

Kidscreen assesses condition and level of function in five life domains, physical/medical, developmental, educational, family/social and emotional/behavioral. The physical/medical domain is assessed via a comprehensive well child exam. The assigned DCFS social worker designs an action plan with the Kidscreen Specialist and includes the Kidscreen action plan as part of the Individual Service and Safety Plan [ISSP]. The social worker shares the Kidscreen action plan with those involved, and tracks implementation of the plan.

Data

Between September 15, 2001 and December 19, 2002, there were 3,347 Kidscreens completed. Out of the completed Kidscreens, 2,417 had a completed EPSDT. There were 930 children who did not have the EPSDT completed during that time frame. The reasons noted for the children not having an examination include:

- 47% of children had an appointment scheduled for an EPSDT in the future.
- 36% of children did not have caregivers who followed through on obtaining the examination.
- 7% had difficulty with their medical coupon payment.

Foster Care Passport Program

Policy

The Foster Care Passport Program (FCPP) is a collaborative, interdisciplinary effort between CA and local Public Health jurisdictions to improve the health status of children residing in out-of-home care for more than 90 days.

The FCPP was specifically designed to identify, gather, and share health history information with those providing care to children residing in out-of-home placement. Additionally, FCPP contracted Public Health Nurses (PHN) provide consultation directly to social work staff and foster parents who are caring for these children. FCPP is not a one-time service, but continues to provide progressive information as the needs of the child change. FCPP actively assists social workers and foster parents in making informed decisions regarding health care needs of children.

Children are automatically referred to FCPP electronically, via CAMIS when they are placed in out-of-home care. However, due to funding limitations, caseload prioritization within the general eligibility criteria has been a necessity, and varies slightly due to the specific needs and PHN staffing level of the regions. In general, the prioritization for creating passports is on children birth through 12 years of age, who remain in out-of-home care 90 days or longer.

Foster parents are routinely instructed to share Passport information with health care providers when children are taken in for appointments. Through implementation and discussion with health care providers, it was determined to be ineffective and inappropriate for FCPP to mail the Passports and/or recommendations directly to health care providers due to confidentiality issues and mobility of children in foster care. It was decided that it was more effective to educate and train foster parents to approach medical care for foster children in the same manner as their own children, by bringing necessary health information with them to any health care appointments. FCPP distribution of information includes:

To social workers:

- An original passport signed by the PHN,
- A letter or recommendations for the PHN outlining specific health issues, the follow-up needed, and where the community resources exist,
- All medical records received from health care providers, and
- If the PHN sees an urgent health issue requiring immediate attention, a "Health Care Concern Alert" is offered to the social worker to notify foster parents

To foster parents:

- A copy of the Passport,
- A letter or recommendations from the PHN outlining specific health issues, and
- Assistance, per requests from the social worker, regarding urgent health issues which may need follow-up, including accessing appropriate community resources.

In 2001, CA received a one-time allocation of funds for Fiscal Year 2002 to create Passports on the backlog of cases that have built up from the program's inception in July, 1997. The one-time allocation totaled \$1,458,000. Half of the funding (\$729,000) was subsequently rolled over into Fiscal Year 2003.

The funds have been kept separate from the normal allocation of funding for the Passport program. Local Public Health Jurisdictions (LPHJ) throughout Washington State were invited to apply for these funds. The contracts for the backlog project are fee-for-service contracts, at a unit price of \$450 per completed Passport.

The project for addressing the backlog of Passports was operationally challenging. A number of LPHJs suffered significant budget shortfalls over the past few years, resulting in a nursing shortage. In the midst of this nursing shortage, the ability of LPHJ's to hire nurses for short-term

work is extremely limited. While the Public Health nursing directors agreed that the use of money was a good idea, it was difficult for most of them to utilize it.

Seven LPHJ's have contracted to work on the backlog project. The contracts do not contain any limit as to the number of backlogged Passports each can produce. Additionally, participating LPHJ's are not limited to the creation of backlogged Passports in their own area.

Because the funding was a one-time event, it was decided to prioritize the backlog. The priorities were:

- 1) Legally free children (the pool of children free for adoption);
- 2) Youth aging out of the foster care system who would be responsible for their own care;
- 3) All others.

Children with special health care needs/issues have always had priority into the FCPP, regardless of their time in care.

Data

Chart one represents the last four calendar years of operation, showing the progress in creating Passports for children in out-of-home care. In FY 2002, approximately 4,814 children met the criteria for a Passport. Passports were completed on 71% of the eligible children. On average, approximately 500 children will leave care between 90-180 days and the Passport may not have been completed.

Chart 1. Foster Care Passport Program

Foster Care Passport Program *Activity Summary Data (by calendar year)*

Activity Summary Data by Calendar Year	Passports Completed	Health and Education Contacts	Case Finding and Referral
1998 Total Numbers*	1,573	1,985	231
1999 Total Numbers	3,860	3,181	116
2000 Numbers	3,821	1,597	137
2001 Numbers	3,104	2,486	350
2002 Numbers**	3,400	2,336	306
TOTAL	15,758	11,585	1,140

***FCPP was implemented in offices statewide throughout the entire calendar year of 1998**

**** 2002 numbers are projections, based on data through August**

The FCPP conducted a statewide satisfaction survey of health care providers, social workers, and foster parents who cared for children who received Passports between June 1 and August 31, 2001.

Table 1. Social Worker Survey

Survey Question	Response to Survey Question
• The Passport program contained helpful information on the child.	93% answered yes
• The health recommendations made by the PHN were helpful.	90% answered yes
• I have followed up on health recommendations made by the Passport program nurse.	82% answered yes
• I have sought consultation from the Passport program nurse.	66% answered yes

Table 2. Health Care Provider Survey

Survey Question	Response to Survey Question
• I have seen a Passport and Health Recommendations Letter for a child residing in foster care who is under my care.	50% answered that they had not seen a Passport. Follow-up contacts were made with providers who had indicated they had not seen a Passport for a child in their care. Some health care providers did locate the Passports as part of their medical records.
• The Passport contained helpful and useful information regarding the child.	96% answered yes
• The recommendations made by the Passport nurse to the foster parent were useful.	96% answered yes

Table 3. Foster Parent Survey

Survey Question	Response to Survey Question
<ul style="list-style-type: none">The Passport contained helpful and useful information that helped me provide care.	<p>87% agreed.</p> <p>The 13% who disagreed indicated that the child had been with them since birth, or they were the grandparent, and knew all their health information.</p>
<ul style="list-style-type: none">I have shared the Passport and recommendations letter with my child's health care provider.	<p>51% said that they had.</p> <p>This is consistent with the above response from health care providers who indicated they had not seen a Passport, and indicates an ongoing training need with both foster parents and providers about the intent/content of the Passport.</p>

(Source: Information from the above tables was taken from Report to the Legislature, Foster and Adoptive Home Placement, December 2002)

Additional Resources to Meet Health Care Needs of Children

Foster Care Medical Unit

The Foster Care Medical Unit (FCMU) in the Medical Assistance Administration (MAA) issues a Categorically Needy Program (CNP) fee-for-service (not managed care) medical identification card to each child in licensed out-of-home care with the Division of Children and Family Services (DCFS).

This process is initiated automatically upon entry of the child's placement in the DCFS Case and Management Information System (CAMIS). The FCMU also offers additional services to facilitate the receipt of medical care by DCFS children not in ordinary DCFS licensed care, i.e., children in pre-adopt homes, children who are receiving an adoption subsidy, etc. Relatives providing care for DCFS children apply for Medical Assistance at their local Community Service Office.

Early Intervention Program/Public Health Nursing Services

The Early Intervention Program/Public Health Nursing Services provide a variety of voluntary Public Health nursing services and information and referral to children and families involved with DCFS. The Public Health Nurse (PHN) is available to assess clients for prenatal care and educational needs, and educate and support families in infant care basics.

The PHN is available to assess the health care needs of children, including conducting developmental assessments and providing education regarding growth and development. The PHN assesses parent-child interaction, including discipline methods, and conducts home hazard and/or safety assessments. The PHN is also available to provide information, support and referrals for victims of domestic violence and families with substance abuse concerns. The PHN provides a written report at 90 days, with any significant changes, at case closing, and by special request, for a dependency hearing. The PHN is also available to participate in case staffings if needed.

Medicaid Treatment Child Care

Medicaid Treatment Child Care (MTCC) provides medically necessary psychosocial services to young children at risk of child abuse and neglect. Prior to entering MTCC, each child is assessed and an individual treatment plan is developed to address the needs identified in the assessment.

The services provided by MTCC include, but are not limited to therapeutic play; individual counseling for behavior modification; family counseling; group interventions with both the child and the parent; monthly home visits; and facilitated groups for caregivers. MTCC is available to families served by DCFS Child Protective Services and Child Welfare Services, and for parents participating in certified Division of Alcohol and Substance Abuse (DASA) treatment programs. MTCC is not available in all locations throughout the state.

Medical Consultation Network (MEDCON)

The Medical Consultation Network (MEDCON) can be reached by a toll-free number (1-800-326-5300). Medical consultation is available to Child Protective Services, physicians, law enforcement, prosecutors, other professionals and the public without charge on such subjects as physical abuse and neglect, medical neglect, sexual abuse, shaken baby syndrome, general pediatrics and the “Baby Doe” issues of treatment, nutrition, and hydration for disabled infants. DCFS Region 4 has hired a part-time Registered Nurse as a health issues consultant to staff. In addition, DCFS Region 4 also has a part-time and on-call pediatrician available for on-site and telephone consultation. Region 6 also has part-time medical consultation staff. Other regions around the state are also working to develop similar systems.

II. Initiatives

Interim Vouchers for Foster Children

A Voucher for Interim Pharmacy and Medical Services for Foster Children has recently been developed as a collaborative effort between MAA, the Washington State Pharmacists Association and Dr. Abe Bergman of Harborview Medical Center. This is intended for use when children are placed in foster care after regular business hours or on weekends when a medical ID card cannot be issued or coverage cannot be verified. This can only be used with children in DCFS paid out-of-home care.

Medicaid Eligibility Quality Control Project #26

This project was developed to determine whether foster children have problems accessing health care, and how much foster parents know about their foster child's medical condition. To gather the information, telephone interviews were conducted with a random sample of foster parents for children who entered foster care after January 1, 2001. Surveys were completed with 177 foster parents in 24 counties.

The surveys found that 95 percent of children in foster care have a primary care physician. The majority of foster parents reported not having experienced many barriers in getting health care. Foster parents in both rural and urban counties reported that the barriers that do exist include lack of providers willing to take Medicaid clients. According to the survey results, system problems made it difficult for foster parents to access medical care for the child, including the lack of a Medicaid identification card and the child's medical history at the time of placement.

In response to the survey, MAA and CA have taken several steps to address the issues raised in the survey. Some of the steps include:

1. MAA's Foster Care Medical Unit is exploring ways to ensure foster parents get timely coupons.
2. CA will work to establish an interface with MMIS, so workers can access information.
3. CA will work to hire public health nurses to collect children's medical history information.
4. Kidscreen specialists will work to gather medical information and screen each child entering foster care.
5. CA will establish a single form for statewide use to give to foster parents information about the child
6. CA will hire Medical Consultants in each region to consult on children's health issues (Region 4 and 6 already have these consultants in place).
7. MAA has increased the rates for EPSDT exams for children in foster care, now nearly double the rate for other children on Medicaid, as an incentive for providers to provide care to children in foster care.

(Source: Information taken from Executive Summary, Foster Kids-Access, Medicaid Eligibility Quality Control Project #26, January 2002)

III. Lessons Learned During the Statewide Assessment

Strengths

- According to peer review reports, Kidscreen Specialists were clearly and accurately completing the assessment tools across all domains 89% of the time.
- CA has developed a system for tracking and monitoring Kidscreen completion. The tracking includes information on the children within each region who need a Kidscreen com-

pleted. In addition, each region, as well as Headquarters, has developed an action plan for improving the completion of Kidscreen.

- CA staff completed 3,445 Kidscreens between September 15, 2001 and December 13, 2002.
- Kidscreen implementation has resulted in a much higher utilization of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) well-child examinations for children entering foster care. Approximately 72% of children placed are now receiving these medical examinations.
- The Foster Care Passport program has been effective and beneficial for those children who were able to receive it. CA received additional funding to decrease the backlog of Passports waiting to be completed.

Challenges

- According to the responses to the Passport survey from foster parents and health care providers, half of the respondent reported they had not seen the Passport for the child in their care. This may indicate the need for training for foster parents and providers about the intent and content of the Passport.
- Among the children who did not receive their EPSDT prior to completion of the Kidscreen, 36% were noted as being due to "no caregiver follow through." It is unknown what percentage of the caregivers were relatives, and what percent were foster parents and/or others. This may be indicative of a need for more education on this issue.
- According to the Case Review Final Kidscreen Report, there needs to be statewide consistency in how to address and incorporate into the action plan issues that are identified in the case record but not identified in the Kidscreen assessment.

COA Self-Study

The Council on Accreditation (COA) requires that the organization ensure that the child receives all necessary physical health services. The standards require that the physical health services include a comprehensive health assessment that consists of:

- a physician's examination, including a screening for communicable diseases, within 30 days prior to admission, or medical or nurse's screening within two working days of entry into care, with a full examination by a physician within 30 days;
- a dental assessment within 30 days before or after entering care for children ages 3 and older;
- identification of medical needs and referral for services;
- an assessment of the need for age-appropriate immunizations within 30 days; and
- hearing, vision, and lead-exposure screenings within 30 days.

According to the Statewide Self-Assessment, Children's Administration is in compliance with this standard. (*Refer to the COA Standards S-21 for additional information*).

Promising Practice:

CA's Strategic Plan (2003-2009) includes strategies to address the health care issues for children. The strategies include:

- the implementation of standardized educational, health, and mental health assessments of children in out-of-home care,
- providing monthly management reports to ensure children are receiving appropriate screenings,
- involving biological parents in well-child/EPSDT exams,
- providing opportunities for participation in their children's health care,
- including health care in child's Individual Safety and Service Plan (ISSP), and
- collaborating with Medical Assistance Administration to obtain needed health care for all children in out-of-home care.

In addition, other strategies include staff training on Kidscreen, establishing a tracking system for annual EPSDT exams, and the development of a method to document when dental care is not accessible. (*Refer to Strategic Outcome WB-2, WB-3, O-1, and O-4*).

4. Mental Health Care for Children.

Examine any data the State has available regarding the mental health needs and status of children in its care and custody. How does the State ensure that the mental health needs of children are identified in assessments and case planning activities and that those needs are addressed through services?

1. Overview

CA policies and procedures require that the mental health needs of children in out-of-home care are assessed and incorporated in the Individual Service and Safety Plan (ISSP). CA initiates the assessment process through the Kidscreen program, and has other services available to children in care to provide more in-depth mental health assessments. The Foster Care Assessment Program (FCAP) also provides assessments as to the health needs of children in care.

The Regional Support Networks support CA by providing the mental health services identified in the assessments.

II. Program Description

Regional Support Networks and Prepaid Health Plans

Washington State's public mental health care is delivered by county-based entities called Regional Support Networks (RSN's). The RSN's are responsible for providing services and supports for acutely or chronically mentally ill adults and severely emotionally disturbed children.

Prepaid Health Plans (PHP's) were created in response to a federal waiver granted to the state to establish regional administration of the Medicaid program. PHP is operated by the Regional Support Network for the area. PHP's replaced a previous fee-for-service structure with a managed care system. It was designed to increase access to care, client satisfaction, administrative efficiency, and create greater accountability for outcomes and quality.

The RSN/PHP's offer a wide variety of mental health services to clients based on their individual needs. Mental health services are provided through licensed vendor pool of community mental health centers. The vendor network includes providers who specialize in certain areas of care.

There are a variety of services available to enrolled clients, including 24-hour crisis response, interpreter services, brief interventions, case management, psychiatric and medical services, in-home services, employment/vocational services, homeless outreach and engagement, housing/residential services, day treatment, individual and group therapy, family therapy, psychiatric consultation to schools, medication management, cultural consultations and culturally appropriate care, education and training opportunities, and consumer/advocate-run services. Services may vary by PHP.

In the RSN/PHP managed care model in King County, there are levels of care called “tiers.”

Tier 1A – Brief Intervention: Short-term, low to moderate intensity, goal-focused therapy, crisis treatment, and family intervention and support.

Tier 1B – Aftercare: Low intensity long-term treatment and support services to child and family to maintain a safe and stable level of functioning. Includes medication prescription and monitoring, medical appointments liaison, case management and 24-hour crisis capability.

Tier 2A – Brief Intensive: Intensive and comprehensive treatment and supports to child and family to avoid hospitalization and incarceration. Includes evaluation and, where appropriate, development of an individualized /tailored care plan (ITCP), brief goal-focused therapy, structured day treatment for all ages 0–21 (3 to 5 hours per day, 5 days per week), school programs, psychiatric consultation to schools, intensive case management and 24-hour crisis capability.

Tier 2B – Maintenance: Long-term treatment and support services to child and family to maintain a safe and stable level of functioning. Includes evaluation and, where appropriate, development of an ITCP, medication prescription and monitoring, case management, 24-hour crisis capability, and family involvement.

Tier 3A – Rehabilitation: Extended treatment and community support to child and family to maintain a safe and stable level of functioning. Includes evaluation and, where appropriate, development of an ITCP, medication monitoring and dispensing, pre-vocational programming, psychosocial rehabilitation, school and after-school programs, intensive case management, 24-hour crisis capability, and coordination and collaboration with other child-serving systems.

Tier 3B – Exceptional Care: Extended intensive and comprehensive treatment and supports to child and family to maintain a safe and stable living situation. Includes evaluation and, where appropriate, development of an ITCP, medication monitoring and dispensing, pre-vocational programming, psychosocial rehabilitation, school and after-school programs, intensive case management, 24-hour crisis capability, and coordination and collaboration with other child-serving systems.

III. Policy Information

CA policy requires that Medicaid-funded RSN/PHP managed care must be the first choice for mental health services for DCFS children. DCFS Program Managers keep social workers informed about how to access the RSN/PHP system. Social workers need to know, for example, how to determine if a child is already a RSN/PHP consumer, and at what tier and where. They also need to know how children access care including how to access 24-hour crisis response, and what hospital emergency rooms will triage children and youth in acute mental health distress.

DCFS direct-funded mental health services are to be used only when RSN/PHP and all other payment resources have been exhausted.

Kidscreen

To assess the emotional/behavioral domain in the Kidscreen, specialists utilize the Achenbach Child Behavior Check List (CBCL). The level of the CBCL that is completed depends on the child's age. The CBCL was completed for 580 children 1.5 to 5 years of age. The majority of these children, 73% (421) had "Total Problems" scores in the normal range. A smaller group of 105 children, or 18%, had clinical scores in the area of Externalizing Problems, such as hitting others, destroying things, screaming, and angry moods.

Thirty five percent of the required assessments were completed. Of those that were not completed, 15% were noted as having a caregiver who was unavailable or uncooperative.

Of the children in the 6-18 year old age group, 1,463 CBCL's were completed. The percentage of children who had scores in the clinical range for "Total Problems" rose to 38%, or 562 children/youth. For "Externalizing Problems," 37%, or 537 children/youth showed scores in the clinical range. Ninety-one percent of assessments were completed. Out of those not completed, 85% were noted as having a caregiver who was unavailable or uncooperative.

CA and the state's Mental Health Division (MHD) have developed a plan for responding to the needs of children scoring in the borderline clinical ranges on the CBCL. CA will refer children whose Kidscreen indicates a need for mental health services to the RSN for further assessment and, if necessary, treatment.

CA is working on a protocol to provide clear direction to social work staff on referring children who have borderline or clinical ranges for assessment and treatment.

Foster Care Assessment Program

Policy

The Foster Care Assessment Program (FCAP) is a statewide contracted program through Harborview Center for Sexual Assault and Traumatic Stress and several of its partner agencies. FCAP assesses children who have been in out-of-home care for more than 90 days and who are in need of intensive planning in order to achieve permanency. FCAP utilizes the services of master's level evaluators in conjunction with pediatricians, psychologists, psychiatrists and other consultants to assess the physical and emotional health of children in foster care who are without a completed permanency plan.

Approximately 20 hours of evaluator time is allocated to the assessment phase. Evaluators review records from the Division of Children and Family Services (DCFS) and conduct structured interviews with the DCFS social worker, the child, caregivers, teachers, Guardians Ad Litem,

and service providers. Evaluators administer several standardized tests and obtain pediatric, psychiatric, psychological, permanency and diversity case consultations.

A comprehensive services and permanency assessment report is provided to DCFS at the conclusion of the assessment. Services after assessment may include the organization and mobilization of key persons in the child's life to review the child's needs and initiate necessary actions to address health, treatment and permanency issues. FCAP evaluators can offer approximately 15 hours to assist the DCFS social worker over a six-month period after the assessment. Approximately six months after the FCAP assessment is completed, the case is closed with a reassessment of the child's level of functioning and permanency status, and the delivery of a termination report to DCFS.

Data

The Foster Care Assessment Program (FCAP) provides an assessment of health, treatment, and permanency needs to guide case planning. In addition, the program provides up to six months of assistance to plan, facilitate, and monitor a service plan.

According to the FCAP annual report published in April, 2001, the program had completed a total of 488 assessments since July 1, 1998. Children assessed by the program frequently demonstrated significant emotional and behavioral problems, insecure attachment and serious functional impairments in the home and at school. These have constituted important barriers to permanency. According to the annual report for FCAP, a significant percentage of children demonstrate clinically significant improvement in their level of functioning when reassessed six months after the initial FCAP assessment.

Children referred for FCAP services have typically been in placement for several years without permanency, although one half have been in care for less than two years. Caucasian boys between the ages of 6 and 12 years are referred most frequently. Beyond the emotional and behavioral needs of these children, FCAP assessments indicate that the caregiver's ability, commitment to permanency, and preference for legal plan constitute important barriers to the finalization of permanency.

The FCAP annual report describes a significant level of unmet need for mental health services among the troubled sub-population it serves. The FCAP annual report also stated that DCFS could make more effective use of the array of available services by educating social workers about effective interventions for specific child conditions, and empowering social workers to become more assertive service brokers and child mental health advocates.

Social workers report there is a problem accessing services for a child who is tiered in one County/RSN and who needs services in another County/RSN. This is because the per-capita treatment dollars flowed into the county where the child is tiered, but CA is asking the other county to incur the treatment costs.

CA has had difficulty utilizing all of the referral slots for FCAP. The target number of referrals for 2002-2003 is 336. As of June, only 278 referrals were made for this fiscal year. This is 58 referrals short of the total target number. Discussions with Regional Administrators on this issue cite two primary reasons for low utilization of the program: 1) staff do not highly value the service; and 2) FCAP providers are not readily accessible throughout the geographically large regions. There have been proposals developed to increase utilization, but to date, neither proposal has been accepted. Although all regions report they are constantly trying to meet targets, no region is successful. Three regions are close. More work can be done in training or educating staff on the value of the service, and finding ways to make the service available throughout the state.

Behavior Rehabilitation Services

Another way that children receive assessment and support related to mental health issues is through Behavior Rehabilitation Services (BRS). This program replaced group care in 1995 and is structured as a package of services wrapped around a child/youth in a group home, a therapeutic foster home, or occasionally, the child's own home. CA recoups Medicaid funding for the rehabilitative services provided under this program. Children/youth accepted into this contracted program present with significant behavioral issues that cannot be managed without significant intervention. Categories of care include: behaviorally and emotionally disordered, developmentally delayed, and sexually aggressive youth. There are also short term services to provide assessment and interim care.

Rehabilitative services provided through BRS are related to functioning in the milieu, such as behavior management, development of social skills, impulse control, and anger management. Children/youth are still able to access RSN resources for issues related to mental health diagnoses and long term issues, often related to the ability of the child to return home.

IV. Initiatives

Working Agreements Between RSN's and CA

An initiative was introduced by the Mental Health Division to increase the services children receive from their local RSN's. Each region is required to develop a protocol between the local RSN and CA to develop an agreement of how children will receive services from the RSN's. This initiative is still in process, and only some protocols been completed.

Kidscreen State and Regional Profiles

Kidscreen assesses condition and level of function in five life domains, physical/medical, developmental, educational, family/social and emotional/behavioral. The Achenbach Child Behavior Checklist (CBCL) is a standardized tool that is used to assess the developmental and emotional/behavioral domains. Using the data gathered from Kidscreens, on a state, and regional basis, CA will develop child profiles to help identify services needed to meet the needs of children.

V. Lessons Learned During the Statewide Assessment

The Region 6 Oversight Committee has been meeting since 1996 on a quarterly basis. The committee is made up of a cross-section of community stakeholders and staff from CA in Region 6. Since January, 2001, the Oversight Committee has agreed to serve as the Child Abuse Prevention and Treatment Act (CAPTA) Citizen Review Panel.

In April, 2001, the Region 6 Oversight Committee began to address mental health issues. The committee focused specifically on the area of local access and availability of mental health services in Region 6. Several new projects were developed during 2002 in Region 6. Those projects include:

- A new position that was jointly funded in Tumwater by CA and the Division of Mental Health
- A child therapy pilot project in Clark and Thurston County, providing free mental health services for children by new therapists with consultation from experienced therapists.

In addition to regional oversight committees and Citizen Review Panels, there is also a statewide committee that services as a CAPTA Citizen Review Panel. The Children, Youth and Family Services Advisory Committee serves as a Citizen Review Panel, and is charged with evaluating the extent to which the state is fulfilling its child protection responsibilities in accordance with its CAPTA State Plan.

Between July 2001 and June 2002, this Citizen Review Board focused on mental health services for children in the Child Welfare system. Following the work of the Citizen Review Panel, the following recommendations were made:

Citizen Review Panel Recommendations Regarding Mental Health Services

(Source: Children's Administration Annual Progress and Service Report, June 30, 2002)

- Develop specific strategies and tasks to carry out the Alternative Response System (ARS) Evaluation Progress Report for recommendations. Include the need for strong leadership within the program.
- Change legislative language in sections RCW 74.13.031(1) RCW 13.34.136 (1)(iv) to clarify the responsibilities between CA and Mental Health.
- Add language to the CA Strategic Plan that focuses on the role of the social worker as a 'team' player and his/her responsibility to build a supportive relationship with the child and family.

- Develop standard language/terminology and clarify definitions related to identification and treatment activities for children with mental health problems. Institute this standard state-wide within the department and with community service providers.
- Develop protocols that ensure each child's needs are thoroughly assessed and treatment plans developed to address the assessed need. Services to support the family and child in following through with the plan should be offered.
- Give children in the child welfare system immediate access to any services needed that receive DSHS funding. The money should follow the child, not the child follow the money.
- Mental health services should be evidence-based and family-centered.
- Develop adequate system for management of medications.
- Hold a DSHS Strategic Planning Summit to develop a comprehensive mental health coordination plan. Attendees should include top-level administrators from each DSHS Department. Topics should address access to services, coordination of services, quality of services, and shared data systems (including Kidscreen).
- Hold an Interdepartmental Strategic Planning Summit to develop a comprehensive mental health plan. Include DSHS, DOH, OSPI, Community Mental Health, and key community-based service providers. Attendees should include top-level administrators.
- Develop and implement an annual customer satisfaction survey of stakeholders to gain insight into issues and serve as a baseline for evaluation. Review the Mental Health Division compliance report, and compare with survey results.
- Bring parity between services available for children and adults.
- Bring parity between children's medical and mental health services, including prevention.
- Hold annual joint meetings between the Children, Youth and Family Services Advisory Committee and the Mental Health Advisory Committee.
- Develop an outcome-based service delivery evaluation strategy to replace the current quantitative strategy.

Strengths

- Each Region is currently working with their local RSN to develop working protocols between CA and the RSN's in an attempt to reach an understanding of how children will receive services.

- The Kidscreen tools utilized to assess the emotional/behavioral domain are standardized, and have provided social workers with important information about the mental health needs of children in placement.
- The development of the regional and state child profiles, based on Kidscreen data, will be valuable in identifying services needed to meet the needs of children in different areas of the state.

Challenges

- Many children who enter foster care have many emotional issues that need lengthy treatment and counseling. The mental health field is structured to provide shorter-term care that does not meet the long-term mental health needs of children in out-of-home care. Relatedly, the emotional issues common to children in foster care often do not meet the medical necessity standard that creates the threshold for mental health services. Lack of a clinical diagnosis may prevent a vulnerable child in need of emotional support and intervention from receiving services through RSN-funded programs.
- The Foster Care Assessment Program (FCAP) has been underutilized in the past two years.

COA Self-Study

The Council on Accreditation (COA) standards require the organization ensure that the child receive all necessary mental and physical health services. Specifically, the standards require that within 30 days after admission, each child will receive a mental health screening performed by a qualified mental health professional, who performs further psychological assessments and treatment when needed.

CA uses the Kidscreen emotional/behavioral domain to assess the mental health of children in care. If needed, the Kidscreen specialists refer a child to the local RSN for further assessment and treatment. According to the Statewide Self-Study for CA, the organization is currently passing in this area, based upon the use of Kidscreen as an assessment tool

Promising Practice

The CA Strategic Plan (2003-2009), Strategic Outcome WB-3 addresses the need to provide children in placement with adequate services to meet their needs. Several strategies have been developed to address this outcome. Strategies include fully implementing Kidscreen, training social workers to clearly document current mental health status of children and relating this to parental behaviors, enhancing the coordination with the Mental Health Division to provide services to children with mental health needs, developing statewide and local initiatives and protocols with RSNs, and improving mental health services and availability through exploration of providers and development of services.